

		FOR OFFICE USE					

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0041616</u> Facility Name: <u>Rosewood Care Center-Inverness</u> Address: <u>1800 Colonial Parkway</u> <u>Inverness</u> <u>60067</u> <div style="text-align: center;">Number City Zip Code</div> County: <u>Cook</u> Telephone Number: <u>(847) 776-4700</u> Fax # <u>(847) 776-7700</u> IDPA ID Number: <u>43-1660453001</u> Date of Initial License for Current Owners: <u>04/12/00</u> Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>4/28/00</u> to <u>10/31/2000</u> and certify to the best of my knowledge and belief that the said content are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Louis J. Netemeyer</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Title) <u>Treasurer</u></td> </tr> <tr> <td>(Signed) <u>See Accountant's Compilation Report</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Cindy A. Tefteller</u></td> </tr> <tr> <td>(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, Illinois 62002</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u></td> </tr> <tr> <td colspan="2"> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>Louis J. Netemeyer</u>	Paid Preparer	(Title) <u>Treasurer</u>	(Signed) <u>See Accountant's Compilation Report</u> (Date) _____	(Print Name and Title) <u>Cindy A. Tefteller</u>	(Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, Illinois 62002</u>		(Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u>																																						

SEE ACCOUNTANTS' COMPILATION REPORT

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number Rosewood Care Center-Inverness# 0041616 Report Period Beginning: 4/28/00 Ending: 10/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)	142	26,554	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7		TOTALS	142	26,554	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			2,067	2,067	8
9	SNF/PED					9
10	ICF		1,864		1,864	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS		1,864	2,067	3,931	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 14.80%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 04/28/00

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 04/12/00NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 58 and days of care provided 2067Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 06/30/2000 Fiscal Year: 06/30/2000

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Rosewood Care Center-Inverness

0041616

Report Period Beginning: 4/28/00

Ending: 10/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	68,340	6,553	1,942	76,835		76,835	0	76,835		1
2	Food Purchase		23,855		23,855		23,855	(125)	23,730		2
3	Housekeeping	47,344	6,979		54,323		54,323	0	54,323		3
4	Laundry	3,979	5,505	0	9,484		9,484	0	9,484		4
5	Heat and Other Utilities			63,148	63,148		63,148	0	63,148		5
6	Maintenance	8,724	5,476	29,509	43,709		43,709	1,966	45,675		6
7	Other (specify):* Sanitation			3,186	3,186		3,186	0	3,186		7
8	TOTAL General Services	128,387	48,368	97,785	274,540		274,540	1,841	276,381		8
9	B. Health Care and Programs										
9	Medical Director							0			9
10	Nursing and Medical Records	399,226	30,886	4,386	434,498		434,498	0	434,498		10
10a	Therapy	465	2,588	98,696	101,749		101,749	0	101,749		10a
11	Activities	11,119	1,373		12,492		12,492	0	12,492		11
12	Social Services	14,978	0	811	15,789		15,789	0	15,789		12
13	Nurse Aide Training							0			13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Programs	425,788	34,847	103,893	564,528		564,528		564,528		16
17	C. General Administration										
17	Administrative			78,096	78,096		78,096	(28,054)	50,042		17
18	Directors Fees							0			18
19	Professional Services			1,800	1,800		1,800	26,229	28,029		19
20	Dues, Fees, Subscriptions & Promotions			15,616	15,616		15,616	(7,602)	8,014		20
21	Clerical & General Office Expenses	41,167	11,946	14,608	67,721		67,721	86,288	154,009		21
22	Employee Benefits & Payroll Taxes			80,374	80,374		80,374	10,773	91,147		22
23	Inservice Training & Education							0			23
24	Travel and Seminar			1,077	1,077		1,077	0	1,077		24
25	Other Admin. Staff Transportation							20,429	20,429		25
26	Insurance-Prop.Liab.Malpractice			2,757	2,757		2,757	1,680	4,437		26
27	Other (specify):*							0			27
28	TOTAL General Administration	41,167	11,946	194,328	247,441		247,441	109,743	357,184		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	595,342	95,161	396,006	1,086,509		1,086,509	111,584	1,198,093		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Rosewood Care Center-Inverness # 0041616 Report Period Beginning: 4/28/00 Ending: 10/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							146,789	146,789			30
31	Amortization of Pre-Op. & Org.							8,189	8,189			31
32	Interest			44,869	44,869		44,869	449,776	494,645			32
33	Real Estate Taxes			217,924	217,924		217,924	0	217,924			33
34	Rent-Facility & Grounds			507,731	507,731		507,731	(503,175)	4,556			34
35	Rent-Equipment & Vehicles							0				35
36	Other (specify):*							0				36
37	TOTAL Ownership			770,524	770,524		770,524	101,579	872,103			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		30,755	4,567	35,322		35,322	(376)	34,946			39
40	Barber and Beauty Shops			1,614	1,614		1,614	0	1,614			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			37,700	37,700		37,700	0	37,700			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		30,755	43,881	74,636		74,636	(376)	74,260			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	595,342	125,916	1,210,411	1,931,669	0	1,931,669	212,787	2,144,456			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

SEE ACCOUNTANTS' COMPILATION REPORT

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Rosewood Care Center-Inverness # 0041616 STATE OF ILLINOIS Report Period Beginning: 4/28/00 Page 5
Ending: 10/31/2000

VI. ADJUSTMENT DETAIL

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,243)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(376)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(125)	2		13
14	Non-Care Related Interest	(44,869)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,500)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,755)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,347)	20		28
29	Other-Attach Schedule Marketing Salary	(11,202)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (65,417)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	278,204	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35) (sum of SUBTOTALS	\$ 278,204		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 212,787		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center-Inverness

0041616 Report Period Beginning:

4/28/00

Ending:

Summary A

10/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary	Operating Expenses												SUMMARY TOTALS (to Sch V, col.7)	
		PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I		
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(125)	0	0	0	0	0	0	0	0	0	0	(125)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	1,966	0	0	0	0	0	0	0	0	1,966	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(125)	0	1,966	0	0	0	0	0	0	0	0	1,841	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(58,096)	30,042	0	0	0	0	0	0	0	0	(28,054)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,635	23,594	0	0	0	0	0	0	0	0	26,229	19
20	Fees, Subscriptions & Promotions	(7,602)	0	0	0	0	0	0	0	0	0	0	(7,602)	20
21	Clerical & General Office Expenses	(12,445)	0	98,733	0	0	0	0	0	0	0	0	86,288	21
22	Employee Benefits & Payroll Taxes	0	290	10,483	0	0	0	0	0	0	0	0	10,773	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	20,429	0	0	0	0	0	0	0	0	20,429	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,680	0	0	0	0	0	0	0	0	1,680	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(20,047)	(55,171)	184,961	0	0	0	0	0	0	0	0	109,743	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(20,172)	(55,171)	186,927	0	0	0	0	0	0	0	0	111,584	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center-Inverness # 0041616 Report Period Beginning: 4/28/00 Ending: 10/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	136,858	9,931	0	0	0	0	0	0	0	0	146,789	30
31	Amortization of Pre-Op. & Org.	0	8,189	0	0	0	0	0	0	0	0	0	8,189	31
32	Interest	(44,869)	494,645	0	0	0	0	0	0	0	0	0	449,776	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(507,731)	4,556	0	0	0	0	0	0	0	0	(503,175)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(44,869)	131,961	14,487	0	0	0	0	0	0	0	0	101,579	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(376)	0	0	0	0	0	0	0	0	0	0	(376)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(376)	0	0	0	0	0	0	0	0	0	0	(376)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(65,417)	76,790	201,414	0	0	0	0	0	0	0	0	212,787	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE ACCOUNTANTS' COMPILATION REPORT

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number

Business Center Location

STATE OF FLA:POLAR

Report Period Beginning

4/3/20

Ending

3/31/2020

Page 4

Sheet 1000

VI. RELATED PARTIES

Sheet Page A (line 4)

Sheet Page A (line 4)

Sheet Page A (line 4)

A. Enter below the names of ALL owners and related organizations (partial) as defined in the instructions. Attach an additional schedule if necessary.

OWNERS		RELATED NURSING HOMES		OTHER RELATED BUSINESSES/ENTER		
Name	Ownership %	Name	City	Name	City	Type of Business
State of Florida	100%	No related info		No related info		
State of Florida	100%	No related info		No related info		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes one: management fees, purchase of supplies, and so forth.

Yes

No

If yes, costs incurred as a result of transactions with related organizations must be fully detailed in accordance with the instructions for Reporting costs as specified for this form.

Schedule V	Line	Date	Amount	Name of Related Organization	City	Operating Cost of Related Organization	Adjustments for Related Organization Costs / Entries
1	1	3/1	95,000	HEIM Management Services, Inc.	FLORIDA	120,000	120,000
1	2						
1	3						
1	4						
1	5						
1	6						
1	7						
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1	19						
1	20						
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1	22						
1	23						
1	24						
1	25						
1	26						
1	27						
1	28						
1	29						
1	30						
1	31						
1	32						
1	33						
1	34						
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1	36						
1	37						
1	38						
1	39						
1	40						
1	41						
1	42						
1	43						

Print Preview

Total must agree with the amount recorded on line 30 of Schedule VA.

SEE ACCOUNTANTS' COMPLETION REPORT

DO NOT USE DELEGATE DRUGS, CTT OR NURSING CONSULTANTS, THEY WILL BE IN THE FUNDING PLAN.

1. Enter the information on pages 5 and 5A.

2. For pages 6 thru 40, the information you enter does not need to be sorted by line reference.

3. For pages 6 thru 40, a line can be referenced as many times as needed per page.

4. For pages 6 thru 40, related organization costs for therapy must be referenced as line number 10h.

5. The adjustments entered on this page will automatically transfer to the summary pages.

Sum, 0

-78000

-907711

110051

40000

8100

2635

20000

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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6A

Facility Name & ID Number Rosewood Care Center-Inverness

0041616

Report Period Beginning: 4/28/00

Ending: 10/31/2000

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 See Schedule VIII	\$	HSM Management Services, Inc.	100.00%	\$ 30,042	\$ 30,042 15
16	V	21 See Schedule VIII		HSM Management Services, Inc.	100.00%	98,733	98,733 16
17	V	22 See Schedule VIII		HSM Management Services, Inc.	100.00%	10,483	10,483 17
18	V	25 See Schedule VIII		HSM Management Services, Inc.	100.00%	20,429	20,429 18
19	V	30 See Schedule VIII		HSM Management Services, Inc.	100.00%	9,931	9,931 19
20	V	34 See Schedule VIII		HSM Management Services, Inc.	100.00%	4,556	4,556 20
21	V	19 See Schedule VIII		HSM Management Services, Inc.	100.00%	23,594	23,594 21
22	V	26 See Schedule VIII		HSM Management Services, Inc.	100.00%	1,680	1,680 22
23	V	6 See Schedule VIII		HSM Management Services, Inc.	100.00%	1,966	1,966 23
24	V						24
25	V						25
26	V						26
27	V						27
28	V						28
29	V						29
30	V						30
31	V						31
32	V						32
33	V						33
34	V						34
35	V						35
36	V						36
37	V						37
38	V						38
39	Total		\$			\$ 201,414 \$ *	201,414 39

Sum_6A

30042
98733
10483
20429
9931
4556
23594
1680
1966

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6B

Facility Name & ID Number Rosewood Care Center-Inverness # 0041616 Report Period Beginning: 4/28/00 Ending: 10/31/2000

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name & ID Number Rosewood Care Center-Inverness # 0041616 Report Period Beginning: 4/28/00 Ending: 10/31/2000

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

- B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number Rosewood Care Center-Inverness # 0041616 Report Period Beginning: 4/28/00 Ending: 10/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Vander Maten	President	Management	75.00%	322,411	2.93	5.86%	Salary	\$ 19,495	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	118,137	2.93	5.86%	Salary	10,498	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 29,993		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

[Print Previe](#)

Facility Name & ID Number Rosewood Care Center-Inverness# 0041616 Report Period Beginning: 4/28/00Ending: 0/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8

Show Pgs 8E thru 8

Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

HSM Management Services, Inc.

Street Address

11701 Borman Drive, Suite 315

City / State / Zip Code

St. Louis, MO 63146

Phone Number

(314) 994-9070

Fax Number

(314) 994-9912

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries - Officers	Total Cost	33,179,356	17	\$ 170,541	\$ 170,541	1,942,838	\$ 9,986	1
2	21	Salaries - Other	Total Cost	33,179,356	17	1,458,062	1,458,062	1,942,838	85,378	2
3	22	Payroll Taxes	Total Cost	33,179,356	17	110,633		1,942,838	6,478	3
4	22	Employee Benefits	Total Cost	33,179,356	17	43,688		1,942,838	2,558	4
5	25	Travel	Total Cost	33,179,356	17	58,303		1,942,838	3,414	5
6	30	Depreciation	Total Cost	33,179,356	17	160,877		1,942,838	9,420	6
7	34	Building Rent	Total Cost	33,179,356	17	77,800		1,942,838	4,556	7
8	19	Professional Services	Total Cost	33,179,356	17	402,930		1,942,838	23,594	8
9	21	Telephone	Total Cost	33,179,356	17	83,567		1,942,838	4,893	9
10	26	Insurance	Total Cost	33,179,356	17	28,692		1,942,838	1,680	10
11	21	Taxes & Licenses	Total Cost	33,179,356	17	3,624		1,942,838	212	11
12	21	Office Supplies	Total Cost	33,179,356	17	140,897		1,942,838	8,250	12
13	6	Maintenance	Total Cost	33,179,356	17	33,567		1,942,838	1,966	13
14	17	Direct - Admin	Direct Cost	1	1	20,056	20,056	1	20,056	14
15	17	Direct - Admin	Direct Cost	16	16	464,220	464,220	0	0	15
16	22	Direct - Payroll Taxes	Direct Cost	1	1	1,447		1	1,447	16
17	22	Direct - Payroll Taxes	Direct Cost	16	16	47,641		0	0	17
18	30	Direct - Depreciation	Direct Cost	1	1	511		1	511	18
19	30	Direct - Depreciation	Direct Cost	16	16	15,744		0	0	19
20	25	Direct - Travel	Direct Cost	1	1	17,015		1	17,015	20
21	25	Direct - Travel	Direct Cost	16	16	99,885		0	0	21
22										22
23										23
24										24
25	TOTALS					\$ 3,439,700	\$ 2,112,879		\$ 201,414	25

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Firstar Bank		X	Construction Financing		11/1998	\$ 11,019,643	\$ 11,019,643	11/2002	Prime+1/4	\$ 494,645	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 11,019,643	\$ 11,019,643			\$ 494,645	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 11,019,643	\$ 11,019,643			\$ 494,645	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Rosewood Care Center-Inverness

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	21,076	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	34,032	2
3. Under or (over) accrual (line 2 minus line 1).	\$	12,956	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	204,968	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	217,924	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	8
	1996	9
	1997	10
	1998	65,994
	1999	67,029

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Previe

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,690 B. General Construction Type: Exterior Brick Veneer Frame Wood Number of Stories One

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☒ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: 283,126 2. Number of Years Over Which it is Being Amortized: 48 Months

3. Current Period Amortization: 4. Dates Incurred: 1998 - 99

Nature of Costs: Loan Closing Costs

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>			\$ <u>1,382,237</u>	1
2					2
3	TOTALS			\$ <u>1,382,237</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Rosewood Care Center-Inverness

0041616

Report Period Beginning:

4/28/00

Ending:

10/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	142			2000	\$ 7,960,398	\$	40	\$ 99,505	\$ 99,505	\$ 99,505	4
5											5
6											6
7											7
8											8
9	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Site Development			2000	386,532		25	7,731	7,731	7,731	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$ 107,236	\$ 107,236	\$ 107,236	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

Facility Name & ID Number Rosewood Care Center-Inverness# 0041616

Report Period Beginning:

4/28/00

Ending:

10/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 68,202	\$	\$ 6,400	\$ 6,400	10 Yrs	\$ 38,743	37
38	Current Year Purchases	592,444		29,622	29,622	10 Yrs	29,622	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 660,646	\$	\$ 36,022	\$ 36,022		\$ 68,365	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	HSM Management	Various	Various	\$ 41,256	\$	\$ 3,531	\$ 3,531	5 Yrs	\$ 16,453	42
43										43
44										44
45										45
46	TOTALS			\$ 41,256	\$	\$ 3,531	\$ 3,531		\$ 16,453	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 146,789	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 146,789	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 192,054	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Section Not Applicable	\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58	Section Not Applicable	\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

XII. RENTAL COSTS**A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease: Schedule Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current
rental agreement:

Fiscal Year Ending

Annual Rent

12. _____ /2001 \$ _____

13. _____ /2002 \$ _____

14. _____ /2003 \$ _____

* If there is an option to buy the building,
please provide complete details on attached
schedule.** This amount plus any amortization of lease
expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

Facility Name & ID Number Rosewood Care Center-Inverness # 0041616 Report Period Beginning: 4/28/00 Ending: 10/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p style="text-align: right;"> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO </p> <p>Schedule Not Applicable - Only Hire Certified Aides If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

Print Preview

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-8	hrs	\$	3,468	\$ 39,015	\$	3,468	\$ 39,015	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		709	7,976		709	7,976	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		4,596	51,705		4,596	51,705	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescripts				26,515		26,515	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-Ray Fees, Amb Fees Other (specify): Lab Fees, Enterrals	39,8 39,3				4,567	4,240		8,807	13
14	TOTAL			\$	8,773	\$ 103,263	\$ 30,755	8,773	\$ 134,018	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center-Inverness

STATE OF ILLINOIS

0041616

Report Period Beginning: 4/28/00

Ending:

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10/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 10/31/2000

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 394,679	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,000)	477,354		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,130		6
7	Other Prepaid Expenses	2,418		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 875,581	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 875,581	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 76,524	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,660,571		29
30	Accrued Salaries Payable	97,423		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,689		31
32	Accrued Real Estate Taxes(Sch.IX-B)	204,968		32
33	Accrued Interest Payable	42,968		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,092,143	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,092,143	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,216,562)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 875,581	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

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		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (258,824)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (258,824)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(957,738)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (957,738)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,216,562)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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STATE OF ILLINOIS

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Facility Name & ID Number Rosewood Care Center-Inverness

0041616

Report Period Beginning: 4/28/00

Ending: 10/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,004,245	1
2	Discounts and Allowances for all Levels	(439,511)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 564,734	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	398,480	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 398,480	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,394	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	1,243	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,637	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,704	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,704	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Lab Discount	376	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 376	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 973,931	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 274,540	31
32	Health Care	564,528	32
33	General Administration	247,441	33
B. Capital Expense			
34	Ownership	770,524	34
C. Ancillary Expense			
35	Special Cost Centers	36,936	35
36	Provider Participation Fee	37,700	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,931,669	40
41	Income before Income Taxes (line 30 minus line 40)**	(957,738)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (957,738)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	909	1,119	\$ 35,184	\$ 31.44	1
2	Assistant Director of Nursing	265	327	8,323	25.45	2
3	Registered Nurses	6,348	7,816	176,358	22.56	3
4	Licensed Practical Nurses	267	329	5,373	16.33	4
5	Nurse Aides & Orderlies	10,558	13,000	160,982	12.38	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	645	794	11,119	14.00	10
11	Social Service Workers	874	1,076	14,978	13.92	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	4,561	5,616	68,340	12.17	15
16	Dishwashers					16
17	Maintenance Workers	670	824	8,724	10.59	17
18	Housekeepers	4,948	6,093	47,344	7.77	18
19	Laundry	400	493	3,979	8.07	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,755	3,392	41,167	12.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	959	1,181	13,471	11.41	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	34,159	42,060	\$ 595,342 *	\$ 14.15	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 1,942	1,3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		811	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 2,753		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	15	256	10,3	51
52	Nurse Aides	517	4,130	10,3	52
53	TOTAL (lines 50 - 52)	532	\$ 4,386		53

SEE ACCOUNTANTS' COMPILATION REPORT

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XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,849 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 37,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. No facility specific audit
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

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